IOWA Health and Human Services

Home and Community-Based Services (HCBS) Waiver Priority Needs Assessment

Individuals applying for HCBS Waiver services who have high needs that may put them at risk for institutionalization should complete this Waiver Priority Needs Assessment (WPNA) form. If the individual applying for HCBS services is unable to fill out the WPNA, another person may fill it out on their behalf. The WPNA asks questions about medical and social history, as well as potential safety risks, which may allow for prioritization on the waiver waiting list.

On this form, "individual" refers to the person who is applying for HCBS waiver services. Please keep this in mind, especially if you are filling out this form for somebody else.

Name of Individual Applying for Waiver	Date of Birth
State ID (if known)	Social Security Number
Person Completing Form (if not individual applying for waiver)	Relationship to Individual (if not individual applying for waiver)
Contact Phone Number	Contact Email

Individual has applied for the following HCBS Waiver:

☐ Brain Injury
☐ Children's Mental Health
☐ Health and Disability
☐ Intellectual Disabilities
☐ Physical Disability

Increased Risk of Institutionalization – Check all that apply and **provide details under each statement checked**. Attach additional documents or sheets as necessary.

1. Is the individual age 55 or older?

   ☐ Yes
   ☐ No

   If yes, what is the age? _____

2. Has the individual stayed overnight at a hospital in the last 3 months for a reason other than giving birth?

   ☐ Yes
   ☐ No

   If yes, how many separate times? Please explain what the individual was hospitalized for each time. Attach additional documents or sheets as necessary.

   _____
   _____
   _____
   _____
   _____

3. Has the individual visited an emergency department (not urgent care) in the last 3 months?

   ☐ Yes
   ☐ No

   If yes, how many separate times? Please explain why the individual visited the emergency department each time. Attach additional documents or sheets as necessary.

   _____
   _____
   _____
   _____
   _____

Emergency Need Criteria – Check all that apply and **provide details under each statement checked**. Attach additional documents or sheets as necessary.

1. ☐ The usual caregiver has died or is no longer able to provide care, and no other caregivers are available to provide needed supports.

   _____
   _____
   _____
   _____
   _____

2. ☐ The individual has lost or will be losing housing within 30 days and has no other housing options available.

   _____
   _____
   _____

_____
_____

3. ☐ The individual is living in a homeless shelter, and no alternative housing options are available.

_____
_____
_____
_____
_____

4. ☐ There is founded abuse or neglect by a caregiver or others living within the home of the individual, and the individual must move from the home.

_____
_____
_____
_____
_____

5. ☐ The individual cannot meet basic health and safety needs without immediate supports. (Not applicable to children under age 18 due to parental responsibility)

_____
_____
_____
_____
_____

6. ☐ The individual is in danger or will experience abuse or neglect if the individual does not receive immediate support or services.

_____
_____
_____
_____
_____

7. ☐ The individual is in crisis and admission to a facility will be expected without supports in the next 30-60 days.

_____
_____
_____
_____
_____

8. ☐ The caregiver is under extreme stress or pressure and will not be able to provide for the individual's health and safety if supports are not provided in the next 30 to 60 days.

_____
_____
_____
_____
_____

Urgent Need Criteria – Check all that apply and **provide detail under each statement checked**. Attach additional documents or sheets as necessary.

1. ☐ The caregiver will need support within 60 days for the individual to remain living in their home.

_____
_____
_____
_____
_____

2. ☐ The caregiver will be unable to continue to provide care within the next 60 days.

_____
_____
_____
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_____

3. ☐ The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

_____
_____
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_____
_____

4. ☐ The individual is living in temporary housing and plans to move within 31 to 120 days.

_____
_____
_____
_____
_____

5. ☐ The individual is losing permanent housing and plans to move within 31 to 120 days.

_____
_____

_____
_____
_____

6. ☐ The caregiver is unable to be employed if services are not available.

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_____
_____
_____
_____

7. ☐ There is a potential risk of abuse or neglect by a caregiver or others within the home of the individual.

_____
_____
_____
_____
_____

8. ☐ The individual has behaviors that put them at risk.

_____
_____
_____
_____
_____

9. ☐ The individual has behaviors that put others at risk.

_____
_____
_____
_____
_____

10. ☐ The individual is at risk of facility placement when needs could be met through community-based services.

_____
_____
_____
_____
_____

By signing below, you certify that your answers are true and correct to the best of your knowledge. If questions arise you may be contacted for further information.

Signature	Date

Return the completed form to:
Iowa Department of Health and Human Services
Iowa Medicaid
Attention: HCBS Wait List
PO Box 36478
Des Moines, Iowa 50315

Or by email to: WaiverSlot@hhs.iowa.gov